Abide Health Medical APC

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Phone #: (725) 205-1578 Fax #: (725) 485-3749

Financial Agreement / Payment Policy

Effective Date: ___ / ___ / _____

This **Financial Agreement / Payment Policy** ("Agreement") is entered into between **[Clinic Name]** (the "Clinic") and the undersigned patient or responsible party (the "Patient" or "Responsible Party") to set forth the financial obligations and payment terms for the behavioral health services rendered by the Clinic.

By signing this Agreement, the Patient (or Responsible Party) acknowledges and agrees to the terms set forth below.

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1. Payment Responsibility

The undersigned agrees to pay for services provided by the Clinic, either personally or through third-party insurance, as follows:

- **Personal Responsibility**: If you are not using insurance or have a deductible, co-pay, or co-insurance, you are personally responsible for the full payment of services rendered.
- **Insurance Coverage**: If insurance is used to pay for services, the Patient agrees to cooperate with the Clinic in submitting insurance claims and understands that the final responsibility for payment rests with the Patient if insurance coverage is not approved or payment is not made.

Insurance Verification: It is the Patient's responsibility to verify eligibility and coverage with their insurance provider before services are rendered.

2. Insurance Claims and Billing

- **Insurance Filing**: The Clinic will submit insurance claims on behalf of the Patient when applicable, but the Patient understands that the Clinic makes no guarantee of payment by the insurance company.
- **Patient's Responsibilities**: The Patient is responsible for understanding the details of their health insurance coverage, including co-pays, deductibles, and any exclusions in their insurance plan. The Clinic is not responsible for determining the scope of insurance benefits or coverage.
- **Payment Due After Insurance**: If insurance coverage is denied or if the insurance company fails to pay for any reason, the Patient agrees to pay the outstanding balance within a reasonable time.

Denial of Payment: If insurance claims are denied, or if the Patient's insurance provider fails to pay for services, the Patient is responsible for paying the full amount due.

3. Payment Methods

The Clinic accepts the following forms of payment:

- **Credit and Debit Cards** (Visa, MasterCard, Discover, American Express)
- **Checks**
- **Cash**
- **Online Payment Portal** (if applicable)

The Patient agrees to make payment by one of these accepted methods at the time services are rendered or within the terms established by the Clinic.

4. Payment Plans

If the Patient is unable to pay in full at the time of service, the Clinic may offer a **payment plan** option. The Patient must request a payment plan prior to receiving services, and the payment plan must be agreed upon by the Clinic and signed by the Patient. Payment plans may include:

- Monthly installments,
- Payment arrangements based on income or financial hardship,
- Any other arrangement acceptable to both parties.

Failure to make payments in accordance with the terms of the payment plan may result in suspension of services.

5. Co-pays, Co-insurance, and Deductibles

The Patient agrees to pay the **co-pay**, **co-insurance**, or any **deductible** amounts as determined by their insurance plan at the time of each visit. These amounts are due at the time services are rendered.

- **Co-pays**: Co-pays are due at the time of service.
- **Co-insurance**: The Patient will be billed for any co-insurance amounts not covered by insurance.
- **Deductibles**: The Patient is responsible for paying the deductible amount for services.

6. Missed Appointments / No-Shows

The Patient agrees to provide the Clinic with at least **24 hours' notice** if they need to cancel or reschedule an appointment. If a scheduled appointment is missed without prior notice, a **no-show fee** will be charged. The standard **no-show fee** is **$50** (or as determined by the Clinic).

If the Patient repeatedly misses appointments or fails to provide adequate notice of cancellation, the Clinic reserves the right to discontinue services.

7. Late Payments

If the Patient fails to make timely payments, the Clinic may charge a **late fee** or **interest charges** on any outstanding balances, as permitted by law. The interest rate on overdue balances will be **1.5% per month** (or as determined by state law).

The Clinic may refer any unpaid balances to a collection agency if the Patient fails to make payment arrangements or if payment is not received within **90 days** of the due date. The Patient will be responsible for any costs incurred by the Clinic in the collection of unpaid debts.

8. Financial Assistance

If the patient is experiencing financial hardship and is unable to pay for services, the Clinic offers financial assistance programs. The patient may be eligible for reduced fees or payment plans based on their income and financial circumstances. To apply for financial assistance, the Patient must:

- Complete a financial assistance application,
- Provide documentation of income and household size, and
- Cooperate with the Clinic in determining eligibility for reduced rates.

9. Refunds

If a payment has been made in error or for services not rendered, the Patient may request a **refund**. Refund requests must be submitted in writing to the Clinic within **30 days** of the payment date. Refunds will be processed within **30 days** of approval.

10. Notice of Privacy Practices and Payment Information

The Patient acknowledges that they have received and reviewed the **Notice of Privacy Practices** from the Clinic, which describes how their health information will be used, disclosed, and protected under **HIPAA** and **Nevada state law**.

- **Financial Information**: The Patient's financial information (e.g., payment history, billing information) may be used by the Clinic for billing purposes and in accordance with **HIPAA** and **Nevada privacy laws**.

- **Communication of Payment Information**: The Clinic may communicate with the Patient via phone, email, or text message regarding payment reminders, billing issues, and overdue balances.

11. Consent for Payment

By signing this Agreement, the Patient acknowledges and agrees to the following:

- The Patient is financially responsible for payment of services rendered by the Clinic.
- The Patient will provide accurate insurance information and will promptly notify the Clinic of any changes.
- The Patient agrees to pay any co-pays, deductibles, or non-covered charges, as well as any fees associated with missed appointments or late payments.
- The Clinic may refer unpaid accounts to collections if payment is not made in accordance with the terms of this Agreement.

12. Acknowledgment

I, the undersigned, acknowledge that I have read, understood, and agree to the terms and conditions of this Financial Agreement / Payment Policy. I understand my financial responsibilities related to the services provided by **[Clinic Name]**, and I agree to make payment in accordance with the terms outlined above.

Patient Name (Printed): _____

Patient Signature: _____

Date: ___ / ___ / _____

Responsible Party (if applicable): _____

Signature of Responsible Party: _____

Date: ___ / ___ / _____

For Clinic Use Only:

- **Clinic Representative Name (Printed):** _____
- **Signature of Clinic Representative:** _____
- **Date:** ___ / ___ / _____